



WASHINGTON STATE HUMAN RIGHTS COMMISSION

EMPLOYMENT INTAKE QUESTIONNAIRE

Telephone: (360) 753-6770 | FAX: (360) 586-2282 | Statewide Toll Free: (800) 233-3247 | Statewide TTY Toll Free: (800) 300-7525

PLEASE NOTE, BEFORE YOU PROCEED:

The Washington State Human Rights Commission has no jurisdiction over employers with fewer than 8 employees, Native American tribes, the federal government, religious employers, claims in which the unfair action took place outside of Washington, or claims in which the last date of harm occurred more than 6 months prior to the filing date of this complaint (or more than 2 years prior in a state employee whistleblower retaliation claim).

Your complaint will not be accepted for investigation if it falls into one of the exceptions above, or does not meet the jurisdictional requirements of RCW 49.60. If your complaint meets the jurisdictional requirements, please complete the entire form.

If you require reasonable accommodation to fill out this form please contact us a 1-800-233-3247.

Mail To: Washington State Human Rights Commission

711 South Capitol Way, Suite 402, P.O. Box 42490 Olympia, WA 98504-2490

Please Print

(Answer all questions as completely as possible. If you **do not know the answer** to a question, fill in blank with "**not known**". If a question **does not apply**, fill in blank with "**n/a**".)

1). Personal Information:

Last Name _____ First Name _____ MI _____

Street /Mailing Address _____ Apt. or Unit # _____

City _____ County _____ State _____ Zip _____

Phone:

Home (____) _____ Work (____) _____ Cell (____) _____

Email address _____

Date of Birth _____ Gender: Male ____ Female ____ Do you have a disability? Yes ____ No ____

Please answer each a) and b) below:

a) Are you ... ? (Check all that apply)

☐ Hispanic ☐ Caucasian ☐ American Indian ☐ Black ☐ Native Hawaiian

☐ Latino ☐ Asian ☐ Alaskan Native ☐ African-American ☐ Pacific Islander

b) What is your National Origin (country of origin or ancestry)? _____

Please provide a name of a person who **does not live with you** so we may contact them on your behalf if we are unable to contact you.

Name _____ Relationship _____

Address _____ City _____ State _____

Zip _____ County _____ Contact: Phone _____ email _____

2). I believe I was discriminated against by the following organization(s): (Check all that apply)

☐ Employer ☐ Union ☐ Employment Agency ☐ Other: (please specify) _____



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If the organization is an employer, provide the **address where you actually worked**.

If you work from home, check here ____ Provide the address of the office to which you reported*.

Please fill out a separate Intake Questionnaire for each Organization involved.

Organization name _____

Address _____ City _____ State _____

County _____ Zip _____ Phone (____) _____

Type of Business _____

*Job Location if different from Organization's address _____

Human Resources Director or Owner Name _____

Phone (____) _____

Number of employees in the organization at all locations: (Please check only one.)

☐ Less than 8 ☐ 8-14 ☐ 15-100 ☐ 101-200 ☐ 201-500

3). Your Employment Data: (Complete as many items as you can.)

Are you a Federal Employee? ☐ Yes ☐ No

Are you a State Employee? ☐ Yes ☐ No

Date Hired: _____ Job Title at Hire: _____

Job Title at Time of Alleged Discrimination: _____

Do you still work for this Employer? ☐ Yes ☐ No

If No, please check ☐ Quit ☐ Discharged ☐ Laid Off Date _____

Pay Rate When Hired: _____ Last or Current Pay Rate: _____

Name and Title of Immediate Supervisor: _____

If Job Applicant, Date You applied for Job: _____ Job Title applied for: _____

4). What is the reason (Basis) for your claim of discrimination? *For example:* If you feel that you were treated unfairly because of race, you should check the box next to "**Race**". If you feel you were **treated unfairly for several reasons**, such as your gender, religion, and/or national origin, you should check **all that apply**. If you complained about discrimination, participated in someone else's complaint, or filed a charge of discrimination, and a negative action was taken, you should check the box next to "**Retaliation**".

<input type="checkbox"/> Age	<input type="checkbox"/> Color (skin shade)	<input type="checkbox"/> Creed/Religion
<input type="checkbox"/> Gender	<input type="checkbox"/> National Origin	<input type="checkbox"/> Disability
<input type="checkbox"/> Sexual Orientation/Gender Identity	<input type="checkbox"/> Race	<input type="checkbox"/> Veteran status
<input type="checkbox"/> Marital status	<input type="checkbox"/> Pregnancy	<input type="checkbox"/> HIV/Hep C status
<input type="checkbox"/> State Employee Whistleblower Retaliation	<input type="checkbox"/> Retaliation	

If you checked **Color**, **Religion** or **National Origin**, please specify: _____



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If you filed a Washington State Employee Whistleblower complaint, answer the next three questions:

When did you file? _____ What was the Issue? _____

With whom did you file the Whistleblower complaint? _____

Other reasons for discrimination: (Explain) _____

5). What happened to you that you believe was discriminatory? Include the date(s) of harm, the action(s), and names and title(s) of the person(s) who you believe discriminated against you. Please attach additional pages if needed, using this same format. (Example: 10/2/2012 - discharged - Mr. John Doe, Production Supervisor.)

a. Date: _____ Action: _____

Name and Title of Person(s) Responsible: _____

b. Date: _____ Action: _____

Name and Title of Person(s) Responsible: _____

6). Why do you believe these actions were discriminatory? (Please attach additional pages if needed.)

7). What reason(s) were you given for the acts you consider discriminatory?

By Whom? _____ His or her job title: _____

8). Describe if there was anyone in the same or similar situation as you and how they were treated. For example, who else applied for the same job you did, who else had the same attendance record, or who else had the same performance. Provide the protected class, such as race, sex, age, national origin, religion, disability, etc. of these individuals, if known, and if it relates to your claim of discrimination. For example, if your complaint alleges race discrimination, provide the race of each person; if your complaint alleges sex discrimination, provide the sex of each person; and so on. Use additional sheets if needed, using this same format.

a. Of the persons in the same or similar situation as you, who was treated *better* than you?

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

b. Of the persons in the same or similar situation as you, who was treated *worse* than you?

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

Full Name: _____

Protected Class(es) (see section 4, page 2) _____



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Description of treatment: _____

c. Of the persons in the same or similar situation as you, who was treated the *same* as you?

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

Full Name: _____

Protected Class(es) (see section 4, page 2) _____

Description of treatment: _____

→ Answer questions 9-11 only if you are claiming discrimination based on *disability*. If not, skip to question 13. →

9). Please tell us if you are a person with a disability.

Check all that apply:

☐ Yes, I am a person with a disability.

☐ I am not a current person with a disability, but I was previously.

☐ No disability, but the organization treats me as if I am a person with a disability.

10). What is the disability that you believe is the reason for the adverse action taken against you? Does this disability prevent or limit your from doing anything? (For example: lifting, sleeping, breathing, walking, caring for yourself, working, etc.).

11). Do you use medications, medical equipment or anything else to lessen or eliminate the symptoms of your disability? ☐ Yes ☐ No

If "yes", what medication, medical equipment or other assistance do you use? _____

12). Did you ask your employer for any changes or assistance (reasonable accommodation) to do your job because of your disability? ☐ Yes ☐ No

If "yes", when did you ask? _____ How did you ask? (verbally or in writing) _____

Who did you ask? (Provide full name and job title of person) _____

Describe the changes or assistance that you asked for: _____

How did your employer respond to your request? _____

13). Are there any witnesses to the alleged discriminatory incident(s)? If yes, please identify them below and tell us what information they have about the discrimination. (Please attach additional pages to complete your response).

a. Full Name: _____ Relationship: _____

Contact: Phone _____ Email: _____

Address: _____ City _____ State _____

What information does this person have? _____

b. Full Name: _____ Relationship: _____

Contact: Phone _____ email: _____



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Address: _____ City _____ State _____

What information does this person have? _____

14). Have you already filed a complaint in this matter? ☐ Yes ☐ No

Provide name of agency and the date of filing: _____

Results? (if any) _____

15). Have you sought help about this situation from anyone? ☐ Yes ☐ No
(such as, an attorney, advocate, or other source)

Provide name of organization/person you have contacted for help and date of contact: _____

Results? (if any) _____



This is the end of the Intake Questionnaire. Please review all pages to assure you have answered all 15 questions with the correct information as you have intended. "N/A" and "unknown" are acceptable answers where they apply for your personal situation.

*If you need more information before filing a charge or you have concerns about the Washington State Human Rights Commission **notifying** the entity about your charge, you may wish to check BOX 1.*

To file a charge NOW, check BOX 2.

Check only one box!

BOX 1

<input type="checkbox"/>	I want to talk with a Washington State Human Rights Commission Investigator before deciding whether to file a charge. I understand that by checking this box I have not filed a charge with WSHRC. I also understand that I could lose my rights if I do not file a charge within 6 months of the date of the discriminatory action.
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BOX 2

<input type="checkbox"/>	I want to file a charge of discrimination. I authorize the WSHRC to look into the discrimination I described in this Intake Questionnaire. I understand the entity that I accuse of discrimination will receive information about the charge, including my name. I also understand that the WSHRC can only accept charges of discrimination based on race, color, religion, sex, national origin, disability, age, sexual orientation /gender identity, veteran status, marital status, HIV/Hep C status and retaliation for opposing discrimination or state whistleblower retaliation. I understand that the Washington State Human Rights Commission has no jurisdiction over religious institutions, employers with fewer than 8 employees, Native American tribes, or the federal government. The WSHRC has no jurisdiction over claims in which the harm took place outside of Washington or in which the last date of harm occurred more than 6 months prior to the filing date of this complaint or more than 2 years prior in the case of a state employee whistleblower retaliation claim. I understand that if my claim does not meet jurisdictional requirements, it will not be accepted for investigation and that there will be no follow-up on this inquiry from the Washington State Human Rights Commission (WSHRC).
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I declare under penalty of perjury under the laws of the State of Washington that I have read the foregoing and that it is true and correct.

Complainant's Signature _____

Today's Date _____